DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2010 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|--|-------------------------------------|
| 25 | | 185309 | B. WING | | |
| | NOVIDER OR SUPPLIER | | 7 | REET-ADDRESS, CITY, STATE, ZIP CODE 118 GOODWIN LANE LEITCHFIELD, KY 42754 | 09/02/2010 |
| (X1) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPROPRIES OF TH | JLD BE COMPLETION |
| F 223 SS=J | #15164) survey was of 08/20/10 to determine with Federal requirem determined to be unsusupervisory review, KY on 08/30/10, and dete Immediate Jeopardy von 42 CFR 483.13 Re Facility Practices, F22 Quality of Life, F250 S Resident Assessment, 483.75 Administration, Quality of Care (SQC) 483.13 Resident Beha and 42 CFR 483.15 Q survey was conducted. The Immediate Jeopar 08/30/10 and determin The facility was notified Jeopardy on 08/30/10. of Compliance (AoC) with the Immediate Jeopar 19/02/10, 483.13(b), 483.13(b)(1 ABUSE/INVOLUNTAR | viated (KY #15163 and KY onducted 08/18/10 through the facility's compliance ents. KY # 15164 was obstantiated. After Y # 15163 was re-opened rmined to be substantiated. Vas identified in the areas eident Behaviors and 3 s/s 'J', 42 CFR 483.15 /s 'J', 42 CFR 483.20 F282 S/s 'J', and 42 CFR F490 S/s 'J'. Substandard was identified at 42 CFR viors and Facility Practices, uality of Life. An extended 08/30/10 through 09/02/10. Id of the Immediate An acceptable Allegation vas received on 09/02/10, opardy determined to be as alleged. (i) FREE FROM Y SECLUSION | F 223 | Submission of this Plan of Correct not constitute admission or agree the provider of the truth or the factor conclusions set forth in the Sta | ment by cts alleged tement of |
| | sexual, physical, and n punishment, and involu The facility must not us or physical abuse, corp involuntary seclusion. | ntary seclusion. e verbal, mental, sexual, | | Deficiencies. The Plan of Correct submitted solely because it is required provision of federal and state. | uired by |
| /1 | RECTOR'S OF PROVIDER/S | EP)IER BEFRESENTATIVE'S SIGNATURE | | LNHA- | (X8) DATE |

Any deficiency realerment and asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient photocilion to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| F 223 Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility falled to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility falled to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected F 223 F 25 F 243 F 245 F 245 F 252 F 223 F 23 F 223 F 23 F 223 F | CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | 0, 0938-0391 |
|--|--------------|--|---|--|-----|---|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC (X4) ID PREFIX TAO REGULATORY OR LSG IDENTIFYING INFORMATION) F 223 Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ansure each resident had the right to be free from mental, physical and sexual abuse. The facility failed to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754 D PROVIDER'S PLAN OF CORRECTION (GACH CORRECTIVE ACTION SHOULD BE (| | | | 1, , | | | | |
| NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC (X4) ID PREFIX TAO (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FRESIX TAO (X4) ID PREFIX TAO (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FRESIX TAO FRESIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FRESIX TAO FRESIX TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF CORRECTION OF COMPLET OF TAO (X4) ID PROVIDER'S PLAN OF COMPLET OF TAO (X5) ID PROVIDER'S PLAN OF COMPLET OF | | | | | | 47 | | |
| SPRING VIEW HEALTH & REHAB CENTER, INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) F 223 Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility falled to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility falled to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected To PROVIDER'S PLAN OF CORRECTION (P.D. PROVIDER'S PLAN OF CORRECTION (P.D. PREFIX TAG) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (P.D. CORRECTION SHOULD BE CONSS-REFERENCED TO HE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTOR TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORREC | | | 185309 | B. WIN | IG | | 09/0 | 2/2010 |
| SPRING VIEW HEALTH & REHAB CENTER, INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 223 Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, Interviews and record reviews, it was determined the facility falled to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility falled to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected ID PROVIDER'S PLAN OF CORRECTION (2006) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PROVIDE SALES PROVIDE SALES PREFIX TAG PROVIDE SALES PREFIX TAG PREFIX | NAME OF PR | OVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| Cathories Cath | SPRING VI | IEW HEALTH & REHAR | CENTER, INC | | 7- | 18 GOODWIN LANE | | |
| F 223 Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility falled to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility falled to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected F 223 F 25 F 243 F 245 F 245 F 252 F 223 F 23 F 223 F 23 F 223 F | VI 141112 VI | | | | ᆚ | EITCHFIELD, KY 42754 | | |
| This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility falled to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility falled to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected Has.13(b), 483.13(b)(i) Free from Abuse / Involuntary Seclusion It is the practice of Spring View Health & Rehab to honor residents right to be free from abuse, corporal punishment and involuntary seclusion. The facility does not use verbal, mental, sexual or physical abuse or involuntary seclusion. | PREFIX | (EACH DEFICIENC | Y MUST SE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | .D BE | (XB) COMPLETION DATE |
| sample of five. On 06/09/10, the facility identified Resident #16 as having behaviors of a sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexually aggressive behaviors, the facility falled to ensure those interventions were effective in managing the resident's behaviors and failed to Identify and implement interventions to prevent potential abuse of other residents. Resident #16 began having sexually aggressive behaviors which impacted other residents of the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10 and 07/22/10. Furthermore, the facility while aware of these incidents, falled to ensure interventions implemented were effective in managing Resident #16's repetitive sexual behaviors and failed to provide appropriate supervision to prevent Resident #16 form abusing residents of the facility. Resident #16 touched Resident #16's repetitive sexual behaviors and failed to provide appropriate supervision to prevent Resident #16 touched Resident #16 had his/her hand ins/her hand in Resident #14's publo area and Resident #14's spants touching Resident #14's publo area and Resident #14 was yeiling for help. Resident #18 was in bed, during the night, when Resident #18 entered Resident #18's room and demanded sex | F 223 | This REQUIREMENT by: Based on observation reviews, it was detern ensure each resident mental, physical and failed to assess and i interventions to preve residents (#7, #14, # sample of five. On 00 Resident #16 as havi nature and became a history of sexual beh- 08/15/10. While the plan interventions to sexually aggressive t ensure those interver managing the resider identify and impleme potential abuse of ott began having sexual which impacted other 07/10/10, and continu 07/19/10 and 07/22/1 while aware of these interventions implem managing Resident # behaviors and failed supervision to prever residents of the facilit Resident #1's pubic a on a sofa in the come Resident #16 had his pants touching Reside Resident #14 was ye was in bed, during th | ns, Interviews and record mined the facility falled to that the right to be free from sexual abuse. The facility implement effective ent sexual abuse for four 18 and #ZZ), in the selected 6/09/10, the facility identified ing behaviors of a sexual abuse of Reeldent #16's aviors in other facilities on facility implemented care address Resident #16's behaviors, the facility falled to into were effective in interventions to prevent interventions to prevent interventions to prevent interventions of the facility on used on 07/12/10, 07/15/10, 10. Furthermore, the facility incidents, falled to ensure ented were effective in \$16's repetitive sexual to provide appropriate intervention #16 from abusing the Resident #16 from abusing the Resident #16 from abusing the Resident #16 touched area while he/she was sitting mon area of the facility. Sher hend in Resident #14's lent #14's publo area and silling for help. Resident #18 e night, when Resident #18 | F. Construction of the con | 223 | F223 483.13(b). 483.13(b)(i) Free from Abuse / Involuntary It is the practice of Spring View F Rehab to honor residents right to from verbal, sexual, physical, and abuse, corporal punishment and it scolusion. The facility does not u mental, sexual or physical abuse o involuntary seclusion. Corrective Measures for Reside Identified in the deficiency: Resident #16 was placed on 1:1 n on 7/22/10. He remained on 1:1 n until the Resident #16 was discha 7/23/10 to a geriatric psych facilit Resident #7 was assessed by nurs following the incident. No signs a symptoms of pain or distress were evidenced by the nurses note of 7. The Social Service Director visite 7/22/10 at 1000 and recorded that resident scoring very poorly on co scale and diagnosis of late Alzhei interview was ineffective." Resid received follow up visits from Soc Services and from the facility Administrator, who has previousl Social Service Director, on at leas separate occasions from 7/22/10 u 7/23/10, with notes describing each Her physician visited on 8/31/10 or reported that she observed no ill e | Health & be free mental avoluntary se verbal, or monitoring nonitoring red on by. Sing staff and e noted as /22/10. Ed on cy if due to ognitive mert #7 cial y been a st eight until ch visit. and | 10/01/2010 |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO | 0. 0938-0391 |
|--------------------------|--|---|----------------------------|--|--|----------------------------|
| | of deficiencies Correction | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A, BUILDING | PLE CONSTRUCTION | (X3) DATE SUI COMPLET | |
| | | 185309 | B, WING_ | | 09/0 | 2/2010 |
| | OVIDER OR SUPPLIER | CENTER, INC | 7 | REET ADDRESS, CITY, STATE, ZIP CODE 18 GOODWIN LANE .EITCHFIELD, KY 42754 | 05/0 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUI.L SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | .D BE | (X5) COMPLETION DATE |
| F 223 | staff that Resident #1- doorway and demand It was identified that the intervence to prevent a at risk for serious injunced that the intervence to prevent a at risk for serious injunced that to a resident reconstruction. The findings include: A review of the facility dated 01/01/07 and resexual abuse defined nature committed for the abuser and in the adult or elderly person's infeabuse can include, but Under the Identification as part of the assessment of the assessment in the adult or elderly person's infeabuse can include, but Under the Identification as part of the assessment in the assessment in the service of the assessment in the facility admitted Rewith diagnoses to include the physician orders the facility was to follo services for Resident in notes revealed Reside verbally aggressive settled to a Certified New American Interview of Resident in the physician orders the facility was to follo services for Resident in notes revealed Reside verbally aggressive settled to a Certified New American Interview of Resident in the physician orders the facility was to follo services for Resident in the physician orders the facility was to follo services for Resident in the physician orders the facility was to follo services for Resident in the physician orders the facility was to follo services for Resident in the physician orders the facility was to follo services for Resident in the physician orders the facility was to follo services for Resident in the physician orders the facility was to follow the physician orders the facility and the phys | 6 had stood in his/her ed sex. The facility's failure to buse had placed residents by, harm, impairment, or ceiving care in this facility. Abuse/Neglect policy, by ised 08/20/08, revealed as "an act of a sexual the sexual gratification of presence of a disabled adult's by its not limited to fondling, in section, the policy stated ment process, residents will hine if the resident displays or that could result in a lincident. Interventions will be propriate. 16's closed record revealed esident #16 on 06/07/10 and Dementia, Unspecified exheimer's Disease. Review is upon admission revealed with up with psychiatric #16. Review of the nurse's ent #16 began exhibiting exual behaviors towards 00 PM, when Resident #16 urse Aide (CNA) while she have with toileting, "You like and "Let me see your | F 223 | Resident #14 was assessed follow incident, had fever of 99.2, but was currently receiving treatment for Usocial Service Director visited with on 7/22/10 following incident and twice again on 7/23/10 to follow to observe for signs or symptoms of Her visits and observations were rin the Social Service progress note 7/22/10 in an untimed entry, in sulfentries on 7/22/10 at 1545 and 193 7/23/10 at 0830 and 1430. Follow initial entry when she notes that the was "upset," each of the subsequent states that there were "no visual sidistress." Interview with the Social Director indicates that the "visual that she was looking for were thing as crying, tearfulness, fidgeting, factorized in the subsequent that she was looking for were thing as crying, tearfulness, fidgeting, factorized in the series of the hospital for an uncondition and her returned is not anticipated. Resident#18 was admitted for sho rehab on 7/9/10 and was discharged 7/14/10. After receiving the report incident, the Social Service Director the resident. She stated that the reexhibited no signs of distress during visit. During her stay, other than the note on 7/11/10 when she reported incident, she exhibited no indicator mood or behavior symptoms. | s JTI. ch resident visited up and distress. ecorded es on besquent 10, on ving the ic resident int entrics gns of al Service signs" gs such icial in normal, hat she is interm id on of the or visited sident ing the ine nurses the | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES_ | · | | | OMB N | O. 0938-0391 |
|---------------------------------------|--|--|-------------|---------|---|---|--------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - 1 | LDING | PLE CONSTRUCTION | (X3) DATE 9L COMPLE | IRVEY |
| | | 185309 | 8, W | iG | | 09// | 2/2010 |
| SPRING V | | ATEMENT OF DEFICIENCIES | lo | 7. L | EET ADDRESS, CITY, STATE, ZIP CODE 18 GOODWIN LANE EITCHFIELD, KY 42754 PROVIDER'S PLAN OF CORRECT | ION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFIDIENCY) | | COMPLETION DATE |
| · · · · · · · · · · · · · · · · · · · | behaviors continued of per the nurses' notes. #16 remarked to anot up (his penis)" and as of it". Additionally, Reshe had "Ever been to The facility requested Resident #16's behaviors exhibited on 06/15/10, the facility revealed Resident #16's behaviors at previous developed a "Behavior developed a "Behavio | on 06/15/10 at 12:00 PM, which revealed Resident ther CNA during care, "Put it sked if the CNA was. "Scared esident #16 asked the CNA if ouched". additional information about for history due to the n 06/09/10 and 06/15/10. Ity received information from istory and Physical and the Administrator, which had a history of sexual facilities. The facility oral symptoms" care plan revealed the following ain that such behavior will rovide opportunities to vent A. Always have 2 CNAs ovided; and, 4. Notify Social yelclan of any change in s exhibited. There was no the facility identified that behaviors could potentially of the facility and there vidence the facility tions requiring supervision ints of the facility would not behaviors. Furthermore, inted evidence the facility niatric services for Resident ty assessed, through the Protocol (RAP), Resident tely impaired cognitive making and socially | F | 223 | Resident ZZ reported the incident Social Service Director during a quassurance interview on 7/27/10. The Service Director followed up with 7/28/10, 7/29/10 and again on 8/5/05 of these interactions are recorded in Social Service Progress Notes. The voiced no concerns with the situat exhibited no signs of distress. She interviewed by the Administrator of 7/28/10. She relayed a similar accevents and stated, "I am a retired Sworker. I know how to deal with like that." A subsequent interviewed conducted on 8/31/10, to make surthere were no late offects from the and the resident stated that she, "wand had not thought anything else This resident is alert and oriented to place, and time. She is independent decision making and is her own clinderistic may have been impacted by the inference of the facility attempted to interview all female residents on 7/27/10 and "Has anyone ever touched you or eyou in a manner that you felt was inappropriate or made you uncomfand "Do you feel safe here at this fone of the residents (Resident #ZZ that a male resident who is no long had said something to her, but she is | uality he Social her on '10. Each on the he resident ion and was also on ount of locial people was that event as fine about it." o person, it in her nical led who ncident: rocess, 100% of asked, ared for ortable?" acility?") stated er here | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | PLE CONSTRUCTION | (X3) DATE 9 COMPLE | |
|--------------------------|--|--|--------------------|---|--|---|----------------------------|
| | ı | 185309 | B. WIN | ie | | no | 02/2010 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | UZIZVIV |
| SPRING \ | /IEW HEALTH & REHAB | CENTER, INC | | 718 GOODWIN LANE LEITCHFIELD, KY 42754 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY REGULATORY OR L | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (XS) COMPLETION DATE |
| F 223 | Continued From page additional intervention resident's care plan did a nurse's note, dated revealed Resident #10 residents' rooms and some pussy, go ask hand than called the stredirected. The note intervened by redirection other evidence of a address this resident's prevent potential abus. Nurse's notes, dated (revealed, "Resident not in room", a nurse's note entry re "Pants down fondling at 8:30 AM revealed the female staff were "Behavior symptome" facility added the follow 07/15/10: an alarm to to be monitored every pharmacist review models and the follow of the follow of the facility added the follow 07/15/10: an alarm to the facility added the follow 07/15/10: an alarm to the monitored every pharmacist review models and the facility added the follow 07/15/10: an alarm to the facility added the follow 07/15/10: an alarm to the monitored every pharmacist review models and the facility and the facility and the facility added the follow 07/15/10: an alarm to the facility added the follow 07/15/10: an alarm to the monitored every pharmacist review models and the facility and th | as were added to the ated 06/15/10. 07/10/10 at 9:30 PM was wandering in other made the statement, "I wanter to give me some pussy" aff "Sluts" when facility staff detailed the facility trock to sheavior in order to e of other residents. 07/12/10 at 9:30 AM, oted in 212 A, female bed, ulated on bed; 212 A On 07/15/10 at 10:40 AM, ovealed the resident had self". Interview on 08/20/10 his behavior occurred in a roommate. The nurse's lied Resident #16 stated all Whores". Review of the care plan revealed the ving interventions on Resident #16 top of door; 15 minutes; and dis. 08/20/10 ar 4:55 PM with Resident #16 had entered enight and said, "Give me ident #18 yelled for the | F | 223 | physical contact with him. Of the residents that were interviewed, 2 coded on the MDS as having seve impaired cognitive decision makinowever; all but two provided ser answers to the direct questions. A Resident's Council meeting water 7/27/10 to review what constitute and how to report it if they were a suspected someone else was being This review of recognizing and reabuse included sexual abuse. The Council meeting was conducted by Social Service Director. Measures Implemented or System Altered to Prevent Re-occurrence Behavior Management was developed abuse, and requirements for staff of Staff were trained regarding this positioning inappropriate behaviors a abuse, and requirements for staff of Staff were trained regarding this positioning on 8/30/10 and continuon oncoming employees before they work. Training was conducted by of Nursing, Quality Management MDS Coordinator, and Nursing Supervisors. This education will be continued until all current employers. | erely ng, nsible sheld on d abuse abused or g abused. porting Resident y the ems ce: Sexual oped on rmation and sexual response. olicy ing with began Director Nurse, e ees wero | |
| | staff and nobody came room when he/she yell reported what had hap | but Resident #16 left the ed for staff. Resident #18 pened to the day shift , Additionally, Resident | | | trained. Six employees remain on absence and will be trained before return to work. The Director of Nu will be responsible to provide train | their Irsing | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

| | COLORCESIONINE C. | MEDIOUR OF CALCED | | | | OMB N | Q. 0938-0391 |
|---------------|---------------------------------|---|--------|------------------|--|---|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | 1 | KULTIF ILDING | PLE CONSTRUCTION | (X3) DATE SU COMPLE | RVEY |
| | , | 185309 | B. Wif | ۷G | | 097 | 2/2010 |
| NAME OF PR | ROVIDER OR SUPPLIER | | _ | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | 2//2010 |
| PDDING V | /IEW HEALTH & REHAB | OFNITED MO | | | 18 GOODWIN LANE | | |
| SPRING V | NEW DEATIN O KENAD | CENTER, INC | | L | EITCHFIELD, KY 42754 | | • |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | 10 | .L | PROVIDER'S PLAN OF CORRECT | TION | A/41 |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF | | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (XS) COMPLETION DATE |
| F 223 | Continued From page | | F | 223 | F223 (continued) | | |
| | | dent #16 had done it to | | | | | |
| | | ady next door to me said | | | any employees that are not price | r to their | |
| | | e it to her". Resident #18 | | | return to duty. The facility adm | inistrator | |
| | | ent's name. Resident #18 | | | was trained regarding the Inapp | ropriate |] |
| | salu what happened " | Didn't make me feel very | | | Sexual Behavior Monitoring po | olicy on | |
| | a MDS accessment of | /her in a cage". A review of lated 7/15/10, revealed | | - 1 | 8/30/10. She completed the Po | est test for | |
| | Resident #18 was indi | anendent and had no | | 1 | training on 8/31/10, | | |
| | | On 08/20/10 at 9:45 AM, | | | The Paguirement to you and our con- | | 1 |
| ĺ | interview with LPN #2 | confirmed that Resident | |] | The requirement to report any a abuse including sexual abuse w | uspected | 1 |
| | #16 had entered Resid | dent #18's room one night | | İ | reinforced along with a review | as of the | ŀ |
| | demanding sex and so | cared him/her. An interview | 1 | | Abuse Policy, Although educat | ion was | |
| | with the Social Service | | | | provided regarding the entire al | nise policy | |
| | | revealed she was called, | | - | an emphasis was placed on reco | enizing | 1 |
| | | at home due to Resident | | ĺ | sexual abuse and inappropriate | behaviors | |
| | #18 reporting to the da | y shift nurse that Resident | | - | and the need to report any suspe | ected abuse | |
| | | er room demanding he/she | | | of any kind. This education wa | s initiated | |
| | | The SSD thought Resident | | - | on 8/30/10 and was continued v | vith | 1 |
| • | | k. No incident report was | | | oncoming employees before the | y began | į |
| | | ere was "no contact, no | | | work. Training was conducted | by Director | |
| | report" The CCD state | ould have done an incident | | - 1 | of Nursing, Quality Managemen | it Nurse, | 1 |
| | anything in the Social | ed she did not document Service Notes and had not | | | MDS Coordinator, and Nursing | Supervisors. | ſ |
| | implemented any new | Interventions. The facility | İ | | This training was continued unt | il all current |] |
| | was unable to provide | evidence of action taken to | | | cmployees were educated. The | Director of | |
| | prevent Resident #16 | rom exhibiting aggressive | | - | Nursing will be responsible to p | rovide | |
| 1 | verbal sexual behavior | s towards other residents. | | | training to any employees that | ire currently | - |
| | | | | | on leave of absence, prior to the | | |
| | Nurse's note, dated 07 | | | | duty, utilizing the previously de process. | scribed | · |
| | revealed Resident #16 | | | 1 | process, | | Í |
| | | on redirected by the staff, | | | A policy was developed on 8/30 | /10 | |
| | | sive and slapped at them. | | | describing the process to be followed | | |
| 1 | | the facility implemented | | | providing behavior monitoring i | ncludine | |
| | any further intervention | other than redirection. | | | one to one monitoring and 15 m monitoring. A record for docum | inute | |
| , | An interview with Hous | ekeeping Staff #1, on | l | | minute monitoring was included | entitle 15 | |
| | | ely 11:45 AM, revealed | | | mate mornoring was menued | with the | 1 |
| | | on 07/22/10 in Resident | | - 1 | | *************************************** | |
| | #14's room. She obsor | ved Resident #16 | [| | | | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO |). 0938-039 <u>1</u> |
|--|--|---|-------------------|-------|--|---|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPILIER/CLIA IDENTIFICATION NUMBER; | - 1 | LDING | LE CONSTRUCTION | (X3) DATE SU COMPLET | |
| | | 185309 | B. WI | 10 | | | |
| ************************************** | 30/4050 00 01/00/150 | 10000 | | Т | | 09/0 | 2/2010 |
| NAME OF PA | ROVIDER OR SUPPLIER | | | 1 | EET ADDRESS, CITY, STATE, ZIP CODE | | , |
| SPRING V | /IEW HEALTH & REHAB | CENTER, INC | | | 18 GOODWIN LANE | | |
| | | | · | _ L | EITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECY) (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (XS) COMPLETION DATE |
| | hand in the front of Rehis/her hand to "rub" inside Resident #14's yelling "help, help' and yelled "No, no, go #16 then "jerked" his/l #14's pants. Residen crying". Housekeepel stanted crying too. Reanything". Additionall staff who entered the remember who) made what [he/she] has beer eview revealed the faresident #14, MDS A as having modified income difficulty in new with Resident #14, on on 08/30/10 at 1:20 Pihad pulled the cover bhand inside my pants #14 told Resident #16 and escorted him/here #14 stated "I'm scared somebody looks at me spoke softly but becam when describing how if get out. An interview capproximately 5:50 PM | nt #14's bed with his/her esident #14's pants using Resident #14's public area pants. Resident #14 was disaying "Get off me". It off help, entered the roomet off [him/her]". Resident her hand out of Resident the hand out of Resident that #14 was "visibly upset and if #1 stated she "almost esident #14 couldn't do by, the Housekeeper stated from to help (couldn't to the statement "Oh, that's in yelling about". Record cility had assessed essessment dated 07/14/10, dependence cognitively with situations only. Interviews 08/20/10 at 3:45 PM and M revealed Resident #16 eack and "put [his/her] and touched me". Resident to "Stop" and staff came but of the room. Resident #14 he loud and pressured he/she told Resident #16 to on 08/19/10 at M, with Nurse Aide (NA) #1, | | 223 | policy. While monitoring is occuresident will remain on the 24 ho to further communicate the need. The charge nurse is responsible to that the monitoring is being comprecorded during their shift. The immonitoring sheets will be reviewed Unit Managers and / or the Direct Nursing at or just prior to each managers and prior to each managers and prior started on 8/30/10 and was conting outcoming workers in all departments and of their shift before reporting. The training was provided by the of Nursing, MDS Coordinator, Quanagement Nurse, and Nursing Supervisors. The Director of Nurbe responsible to provide training employees that are currently on leads absence prior to their return to during the previously described. A post test was given to verify understanding of the abuse policy reporting requirements and recogning propriate sexual behavior at the conclusion of the training. The Administrator successfully complepost test with a score with 100% a | ur report, to monitor. to assure pleted and individual ed by the tor of coming tion. cess was ued with ents at the g for duty. Director hality sing will to any ave of cy, process. | |
| | #16 had a favorite root across the hall from his frequent redirection ou | g. NA #1 stated Resident m (Resident #14's) located m/her and required t of that room. 10 at 4:00 PM with family | | | Education of the Inappropriate Ser Behavior Management Policy and Behavior Monitoring Policy have added to the orientation materials covered with the Abuse Policy at to of hire. | cual the been that are | |

2593205

PRINTED: 09/27/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI.IA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 9. WING 185309 09/02/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE SPRING VIEW HEALTH & REHAB CENTER, INC LEITCHFIELD, KY 42754 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 223 Continued From page 7 F 223 F223 (continued) revealed he/she had witnessed on 07/22/10. Resident #16 rubbing Resident #7's leg and then Monitoring Measures to Maintain Onmoved his/her hand and began rubbing Resident: going Compliance; #7's pubic area. Resident #7 was half asleep on the couch and did not know what was happening. Review of the 24 hour Nursing reports will The family member stated "it made me feel bad". be conducted daily, by the Director of Nursing or Unit Managers in her absence, Review of a nurse's note, dated 07/22/10 at 3:20 to identify the onset of or changes in. PM, revealed Resident#16 was observed pulling behaviors that are sexually inappropriate. the cover off a female resident and told staff he/she was "up to meanness". On weekends and holidays the on call nurse will verbally review the 24 hour reports by On 08/31/10 at 3:15 PM, interview with Resident phone to identify a new onset of sexually #ZZ (identified by the facility during the inappropriate behaviors. If sexually investigation of 07/22/10 incident), who the facility inappropriate behaviors are identified, the assessed as cognitively independent, revealed on call nurse will come in to review Resident #16 had been to the doorway of his/her interventions which are to be based on the room on two occasions and requested sex. assessment of contributing / causative Resident #ZZ stated he/she remembered telling a factors and report findings to the Director nurse but could not recall who and told the Social of Nursing and / or Administrator. Such Service Director on 07/27/10. interventions include but are not limited to:

On 08/20/10 at 9:45 AM, an interview conducted with LPN #2 revealed Resident #16 had entered other residents' rooms several times and Resident #16 would wait for one resident to leave a room, leaving the other resident alone. Resident #16 knew what he/she was doing and at no time did she see him/her confused as he/she focused on female residents, LPN #2 stated Resident #16 made her feel "uneasy".

An interview conducted with LPN #1, on 08/20/10 at approximately 8:30 AM, revealed Resident #16 had behaviors of staring at everybody's bottoms and entering other residents' rooms. LPN #1 stated she thought Resident #16 had a purpose for entering some rooms in particular and thought he/she "preyed on female residents". She also

behaviors.

treat the underlying condition, separate

residents involved if unable to consent.

a private room if roommate is at risk,

provide diversional activities, obtain

psychiatric evaluation or treatment,

medication plans, provide privacy if

resident is sexually aroused, remind

inappropriate behaviors by joking with

resident about them, provide positive

feedback to resident for appropriate

resident of boundaries of what is

inappropriate, don't encourage

relocate resident who exhibits behaviors to

PRINTED: 09/27/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 185309 09/02/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE SPRING VIEW HEALTH & REHAB CENTER, INC LEITCHFIELD, KY 42754 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X9) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 223 Continued From page 8 F 223 F223 (continued) stated the last incident, on 07/22/10 with Resident #14 was a deliberate choice because Resident A follow up post test to validate on-going #14 was non-ambulatory and located directly understanding of education including, across from Resident #16. Additionally, LPN #1 Abuse & Neglect, reporting of abuse, stated the facility had placed a door alarm on recognition of sexually inappropriate Resident #16's door because he/she had been in behaviors, reporting sexually inappropriate other residents' rooms touching him/herself. The behaviors, and managing sexually facility had utilized 15 minute checks but "In 15 inappropriate behaviors. The testing will be minutes Resident #16 could do what he/she did to conducted every two weeks for eight weeks. Resident #14". LPN #1 stated, "I was scared of If results indicate that someone doesn't Resident #16 myself" and had told the understand, re-education will be provided administrative staff. on an individual basis. After eight weeks, if results of testing indicate understanding, An interview on 08/20/10 at 12:20 PM, with the re-testing will be conducted monthly for six Director of Nursing (DON), revealed nurses were months then quarterly. Monthly reresponsible to ensure a resident's care plan was education will be conducted for three updated if an immediate intervention was needed. months then will be conducted quarterly by She thought Resident #16 had been on 15 minute the Social Service Director, Director of checks but on 07/15/10 she had added "to be Nursing, Quality Management Nurse or a monitored every 15 minutes" with a date of guest speaker. 07/10/10. Additionally, on 07/15/10, "alarm to top of door* and Pharmacist reviewed meds* was added. The DON did not know if the 15 minute checks were placed on the Nurse Aide care plan. Interviews with LPN #2 on 08/20/10 at 8:30 AM. LPN #1 on 08/20/10 at 9:45 AM, the SSD on

08/20/10 at 11:45 AM, and CNA #3 on 08/20/10 at 3:10 PM, revealed they thought Resident #16 might have been on 15 minute checks off and on

responsible to ensure the checks were completed and no flow sheet was utilized to verify if checks were completed. A review of the Nurse Aide Data Sheet (not dated) revealed two assist with all care and door alarm for a safety device. The Nurse Aide Data Sheet did not Indicate 15 minute checks. The Behavior Interventions sections was blank. The care plan titled "Behavioral symptoms

but no particular staff was assigned as

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

| T | THE PROPERTY OF | ARINDANIA ARIZATA | | | | OMB I | NO. 0938-0391 |
|--------------------------|--|--|-------------------|-------------------|---|--|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - 1 | IULTIPI ILDING | LE CONSTRUCTION | (X3) DATE (| SURVEY |
| | | 185309 | B. Wil | 16 | · · · · · · · · · · · · · · · · · · · | 09 | /02/2010 |
| NAME OF PI | ROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | ************************************** | , |
| SPRING V | /IEW HEALTH & REHAB | CENTER, INC | | 71 | 6 GOODWIN LANE EITCHFIELD, KY 42754 | | |
| 5441.55 | CID B (15V AF | | 7 | <u> </u> | TICHPIELD, NY 42/54 | | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| | (#6145) revealed 15 m 07/10/10 that the DON placed on the care plat documentation for 15 verified. An interview with the // 08/19/10 at approximates Resident #16's behavithe morning meetings present reality and that unacceptable. Reside with orders to follow up and a psychiatric evaluation was not obte further revealed the fact checks of Resident #16 behaviors but the facility determine who was confurted for 15 minuted Administrator confirme initiate 1:1 supervision 07/22/10, after the resident's public are initiated transfer of Respectived 09/02/10. An acceptable Allegation was received 09/02/10. #16 was placed on 1:1 after the incident and reuntil 07/23/10 when he/geriatric psychiatric facility on order the incident and reuntil 07/23/10 when he/geriatric psychiatric facility on order the incident and reuntil 07/23/10 when he/geriatric psychiatric facility on order the incident and reuntil 07/23/10 when he/geriatric psychiatric facility of acceptable facility of acceptable psychiatric facility on 0 facilit | Initially checks, dated I had stated she actually in on 07/15/10. No other minute checks could be administrator conducted of the county of the checks could be and staff were told to this/her behaviors were not #16 had been admitted to with psychlatric service useling was discussed then the county of the checks of the checks. The county had no method utilized to minute the checks. The different the facility did not of Resident #16 until dent was observed by staff sident #14's pants, rubbing the checks. The county of the county of | F | 223 | | | |
| | assessed tollowing the | Incident. The SSD visited | | | | | 1 1 |

PRINTED: 09/27/2010 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B, WING 185309 09/02/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE SPRING VIEW HEALTH & REHAB CENTER, INC LEITCHFIELD, KY 42754 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG GROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 223 Continued From page 10 F 223 with the resident on 07/22/10 following the incident and twice again on 07/23/10 to follow up and observe for signs and symptoms of distress as crying, tearfulness, fidgeting, facial expressions and changes in voice from normal. Resident #14 was discharged to a hospital on 07/23/10 with a diagnosis of Pneumonia and is no longer a resident at the facility. Resident #7 was assessed by nursing staff following the incident and showed no signs and symptoms of pain or distress. The SSD and Administrator (a former Social Worker) visited Resident #7 eight times from 07/22/10 to 07/28/10. The resident did not show any changes in behavior as crying, tearfulness or unpleasantness which would have been abnormal for this resident. The actions taken to verify the removal of immediate Jeopardy included review of the policy developed regarding Inappropriate Sexual Behavior Management on 08/30/10. Verified training was completed for the Administrator, \$\$D and staff were trained by Quality Management Specialist Nurses regarding this policy beginning on 08/30/10 and continuing with on-coming employees before they began work. A review was conducted of the Abuse Policy with an emphasis placed on recognizing sexual abuse and inappropriate behaviors and the need to report any suspected abuse of any kind. A review of the policy developed on 08/30/10 described the process to be followed when providing behavior

monitoring including 1:1 monitoring and every 15 minute monitoring. The completion of the post test taken by the Administrator and staff to verify understanding was reviewed. The Director of Nursing, MDS Coordinator, Unit Managers, SSD, Activity Director, Dietary Director, Rehab Director and Administrator were provided training

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB N | 0.0938-0391 |
|--------------------------|--|--|-------------------|------------------|--|------------------------|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | iultipi Lding | LE CONSTRUCTION | (X3) DATE SU COMPLE | JRVEY |
| | | 185309 | B. WIN | 10 | | 09/0 | 02/2010 |
| | ROVIDER OR SUPPLIER VIEW HEALTH & REHAB | CENTER, INC | | 71 | EET ADDRESS, CITY, STATE, ZIP CODE 8 GOODWIN LANE EITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (XG) COMPLETION DATE |
| 1 | arise and monitoring to approaches that were conducted by Quality Nurses on 08/31/10. A review of the new in Behavior Management was conducted 08/31/Administrator and SSI in-serviced by the Quality Nurses on 08/30/10. With CNAs, LPNs and received the in-service Inappropriate Sexual is policy. The DON was list of employees not rand testing to ensure prior to their return to education of the Abus regarding the entire at inappropriate behavior abuse. This education 08/30/10 and was conemployees before they was conducted by the Nurse, MDS Coordina The DON was to be retraining to any remaining related to the inferior of the policy and review of the verifying their attendant the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. The Additional conducted with the post tests. | e plan of care as conditions he effectiveness of the in place. The training was Management Specialist deppropriate Sexual it policy dated, 08/30/10, 10. Interviews with the confirmed they were allty Management Specialist interviews were conducted RNs to confirm they had related to the new Schavior Management responsible to maintain a readily available for training the training was completed duty. Additionally, re Policy was provided buse policy and re and recognizing sexual re was verified initiated on tinuing with on-coming y began work. This training DON, Quality Management tor and Nursing Services. sponsible to provide the ng employees before their tows on 09/01/10 and with CNAs, LPNs and RNs deived the in-services and the lappropriate Sexual to policy. The staff were | F | 223 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SUI COMPLET | |
|---------------------------------------|---|---|--|---|--|----------------------------|
| | | 186309 | B. WING | | 09/0 | 2/2010 |
| | ROVIDER OR SUPPLIER | CENTER, INC | 7 | EET ADDRESS, CITY, STATE, ZIP CODE 18 GOODWIN LANE EITCHFIELD, KY 42764 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | ILD BE | (XS) COMPLETION DATE |
| F 223 | The Immediate Jeopa on 09/02/10, as allegal scope/severity lowers facility's need to conti implementation of sys 483.15(g)(1) PROVIS RELATED SOCIAL S | reviews and interviews of aled no concern. Indy was verified removed and in the AoC, with the dot on a "D", based on the nue to evaluate the atematic changes. ION OF MEDICALLY ERVICE ide medically-related social maintain the highest mental, and psychosocial | F 223 | F250 483.15(g)(1)Provision of medical Social Service It is the routine practice of this for provide medically related social attain or maintain the highest prophysical, mental and psychosocibeing of each resident. | acility to services to acticable | 10/01/2010 |
| · · · · · · · · · · · · · · · · · · · | by: Based on interviews a determined the facility appropriate and timely provided for two resides elected sample of 5. Director (SSD) failed being of each resident their emotional and psto ensure effective intand implemented who behaviors which result the resident or other ro6/09/10, the facility is having behaviors of a aware of Resident #16 behaviors in other facility implemented address Resident #16 | y social services was ents (#16 & #18), in the The Social Service to promote the general well at through identification of sychosocial needs and falled enventions were developed an residents exhibited ted in negative outcomes to desidents of the facility. On dentified Resident #16 as sexual nature and became | | Corrective Measures for Resid Identified in the deficiency: Resident #16 was placed on 1:1 on 7/22/10. He remained on 1:1 until the Resident #16 was disch 7/23/10 to a geriatric psych facil Resident#18 was admitted for sirchab on 7/9/10 and was dischar 7/14/10. After receiving the repoincident, the Social Service Directhe resident. She stated that the exhibited no signs of distress durisit. During her stay, other than note on 7/11/10 when she report incident, she exhibited no indicar mood or behavior symptoms. | monitoring monitoring arged on out of the ctor visited resident ring the the nurses ed the | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

| <u> </u> | O LOD WIEDIONICE | MEDIOWIN SEKVICES | | | | OWB N | <u> </u> |
|---|--|---|--|--|---|--|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER; | (X2) M A. BUI | | LE CONSTRUCTION | (X3) DATE SU COMPLET | RVEY |
| , | ••• | 185309 | B: WIN | iG <u>-</u> | | 09/0 | 2/2010 |
| | ROVIDER OR SUPPLIER | CENTER, INC | | 71 | EET ADDRESS, CITY, STATE, 2IP CODE 18 GOODWIN LANE | | |
| · • · · · · · · · · · · · · · · · · · · | | | | LE | EITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X6) COMPLETION DATE |
| F 250 | Continued From page | | F | 250 | F250 (continued) | | |
| | resident's behaviors a residents within the fall having sexually aggreaffected other resident and continued on 07/2 and 07/22/10. The fail and manage Resident behaviors resulted in the behaviors resulted in the behaviors resulted in the behaviors and paycho 4/16 were met after Resident #16 entered night and demanded sit was identified that the intervene, manage and prevent abuse had plate. | cility. Resident #16 began ssive behaviors which ts of the facility on 07/10/10, 12/10, 07/15/10, 07/19/10, ure to effectively address #16's sexually aggressive two residents (#7 and #14) It by Resident #16. It by failed to ensure the social needs of Resident #18 reported his/her room during the tex. The facility's failure to desupervise behavior's to used residents at risk for impairment, or death to a | The state of the s | To the state of th | How other residents were ide may have been impacted by to have been impacted by to have been impacted by the facility attempted to intervial female residents on 7/27/10 other residents who may have be impacted by the incident. Of the residents that were interviewed coded on the MDS as having so impaired cognitive decision may however all but two provided answers to the direct questions. A Resident Council meeting we 7/27/10 to review what constitution how to report it if they were suspected someone else was be This review of recognizing and abuse included sexual abuse. To | he incident: ce process, ew 100% of to identify been ne 43 l, 27 were everely sking, ensible as held on uted abuse e abused or ing abused. reporting he Resident | |
| ************************************** | included the SSD function nursing home and its' and general well being of eldentification of their eldentification of their eldeneds and works with to meet and sustain the assures timely progress the facility. An intervie on 08/20/10 at 5:20 Ph duties included completes assessments and developments. | residents by promoting the each resident through motional and psychosocial staff in developing a means ese needs. Additionally, is notes on each resident in w with the Administrator, if the content in | Protection of the control of the con | Paralle displaces | Council meeting was conducted Social Service Director. Clinical records were reviewed other residents who exhibit beh may suggest that they have the exhibit inappropriate sexual bel toward residents in the future. It was completed using daily track which identify behavior MDS is including physical and verbal a records of these residents were and the care givers for these resinterviewed to identify if any bewere of a sexual nature. None widentified. This review was considered. | to identify aviors that potential to haviors This review king records ndicators buse. The reviewed idents chaviors were | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO |), <u>0938-0391</u> |
|---|-------------------------------|---|-------------------|-----------------|---|--------------------------|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IULTIP LDING | PLE CONSTRUCTION | (X3) DATE SUI COMPLET | |
| | | | | | , | | |
| | | 185309 | B, WI | √G | | 09/0 | 2/2010 |
| NAME OF PR | OVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| SPRINGV | TEW HEALTH & REHAB | CENTERLING | | 7 | 18 GOODWIN LANE | | |
| OI KING F | TENT TEXT TO A COLOR | ocitizații il d | | L | EITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMFLETION DATE |
| F 250 | Continued From page | 3 14 | F | 250 | F250 (continued) | | |
| | revealed the facility a | dmitted Resident #16 on | | | | | |
| | | ses to include Dementia, | | | Quality Management Specialis | | |
| | | sorder and Alzheimer's | | | Director of Nursing and Unit M | | |
| | | ne admission physician | | | The review was completed on (|)9/30/2010. | |
| | orders revealed the fa | acility was to follow up with | | | Management turntomouted or Co | untormo | |
| | , | 16 began exhibiting sexual | | | Measures Implemented or Sy Altered to Prevent Re-occurr | | |
| | | if and continued these | | | Attered to Frevent Resoccus | onco. | |
| | behaviors on 06/15/1 | | | | On 8/31/10 re-education was co | onducted | : |
| | Administrator receive | d a History and Physical | · | | with the Social Service Directo | r by the | |
| | | vhere Resident #16 resided | | | Quality Management Nurse. Tl | | |
| | , | ealed Resident #16 had a | | | education included review of the | | |
| | | aviors at previous facilities. | | | Scrvice Director's Job Descript | | |
| | | a "Behavioral Symptoms" | | | and Neglect Policy including th | | |
| | | 5/10, which revealed the | | | abuse, identifying abuse and re | | |
| | | s; 1. Explain that such | 1 | | requirements. An emphasis wa | | |
| | behavior will not be to | aggressive feelings; 3, | | | sexual abuse and sexually inapp | | |
| | Always have 2 CNAs | | | | behaviors as well as participation | | |
| | | tify Social Services (SS) and | | | development of care plans and ventions to address sexually in | | |
| | Physician of any char | | | | behaviors and to promote the sa | | |
| | behaviors exhibited. | | | | wellbeing of other residents. The | | |
| · · . | | · | | | Service Director was able to lis | | |
| | A review of the Minim | | | | of abuse, provide examples of | | |
| | | 3/20/10, revealed the facility | | | type, including sexual, physical | | |
| | | 16 as having moderate | | | verbal, corporal punishment, ex | ploitation, | |
| | | with supervision required. | | | or involuntary seclusion and de | escribe the | |
| | | Resident #16 as having | | ļ | abuse reporting process. | | |
| | | behaviors on the Resident | | | | <i>i</i> | |
| | | (RAP), dated 06/20/10 and narks made to staff but no | | | In the same training session, the | | |
| | | ns were implemented at that | | | Service Director was re-educate | | |
| | time. | te in each middle mineral man and an and | | | utilizing the admission history | | |
| *************************************** | | | | Į | assessment process to aid in ide potential risks for inappropriate | | |
| | Record review reveal | ed Resident #16 began | | | behaviors. If potential risks are | | |
| | | aviors impacting other | | | the Social Service Director was | | , |
| | residents of the facility | | | | notify the Administrator and /o | | |
| | | making sexual remarks, | | ١ | Nursing or the On-Call designe | | |
| | masturbating and ejac | culating on a another | | | | | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO |) <u>. 0938-0391 </u> |
|--|--|---|-------------------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | 1 | IULTIPI LDING | LE CONSTRUCTION | (X3) DATE SUF COMPLET | |
| | | 185309 | B. WI | 10 | | 09/0: | 2/2010 |
| NAME OF PR | OVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| 08801010 | PIALITEAT THE CONTRACT | APUTCA 1814 | | 1 | IS GOODWIN LANE | | |
| SPRING V | IEW HEALTH & REHAB | CENIER, INC | | LI | EITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF YAG | ix (| PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 250 | Continued From page | ÷ 15 | F | 250 | F250 (continued) | | |
| F 200 | resident's bed, fondling another resident and redirected which begin continued on 07/12/1 07/22/10. On 07/22/1 housekeeping staff of rubbing Resident #14 resident's pants. Interesident's pants. Interesident's pants. Interesident #16 rubbing moved his/her hand a #7's pubic area. Theresocial services addressed implementation of the implementation of the 2. A review of a MDS 07/15/10, revealed the Resident #18 as indecognitive impairment. To the facility on 07/05 rehabilitation. Review 07/11/10 at 9:00 AM, reported to facility state his/her room during the fift the room when Renurses. The nurse's was "upset" and require be kept shut. An interesident which in the facility and require the room when Renurses. The nurse's was "upset" and require the room when Renurses. The nurse's was "upset" and require the room when Renurses. The nurse's was "upset" and required to facility states the room when Renurses. The nurse's was "upset" and required to facility states and required to facil | ng hin/herself in front of slapping at staff when an on 07/10/10 and 0, 07/15/10, 07/19/10 and 10, per interview observed Resident #16 's pubic area inside the rview with family member #1 the facility) on 08/20/10 at a family member observed Resident #7's leg and then and began rubbing Resident as was no evidence that asked Resident #16's aviors since the care plan on 06/15/10. It assessment, dated assessed pendent and with no Resident #18 was admitted by 10 for short-term of the nurse's notes, dated revealed Resident #18 ff that Resident #16 was in the night, demanded sex and asident #18 yelled for the note revealed Resident #18 ested that his/her room door rview with Licensed #2, on 08/20/10 at 9:45 | p. | 250 | not available. If immediate interrequired she was trained to notificharge nurse of the potential risk in the development of the care plinterventions to manage the potential raining was provided. Social Service Director on 9/1/10 Quality Management Specialist. training included recording in obterms, noting specific observation described clearly using words to visual picture, observing for moon behavior indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators to aide in association indicators by the reside describe feelings objectively. The also instructed to document situation in that occur between roquarterly documentation that may impact on the residents psychosofiunctioning. This would include events as newly identified or work behavioral symptoms, need for of services, a change in medical continuation in the impact of that documentation in was trained that documentation y the cand assist lan and ential risk. d to the 0 by the The plective ons that are paint a od and acssing for ents to help the training ations and outine by have poial by such resening of putside addition that we in family to stressful events. She was to be ng the so that | |
| | morning of 07/11/10, his/her room the prev sex. LPN #2 notified was the SSD. During #18, on 08/20/10 at 4 that the incident "didn | that Resident #16 came in lous night and asked for the on-call supervisor who g an interview with Resident :55 PM, Resident #18 stated 't make me feel very good". : #18 stated staff had told | and party point from a second | The state of the s | also included the need for gather complete and accurate social hist assessment to utilize the informa identify risk for behaviors or conthat require social service or | ing tory and tion to | |

| F 260 Continued From page 16 him/her that Resident #16 did it to others and it was not good for htm. Further review of the record revealed no evidence the facility addressed the incident through Social Services with Resident #16. An interview with the SSD, on 08/20/10 at 11:45 AM, revealed she had been working as the SSD since 07/01/10 with experience working in this position from 06/2009 through 03/20/10. The SSD revealed she was called on 07/11/10 (Sunday), at home, due to Resident #16 was asking for sex. The SSD stated that no incident report was completed because there was "no contact, no injury and the nurse would have done an incident report". The SSD stated after reading the Resident #16's nurse's notes, dated 07/11/10 at 9:00 AM, the incident "looks like verbal sexual abuse". The SSD did not document anything in the Social Service will be reviewed more and further eviewed to verify that medically related social services were identified and provided as necked. The reviews were conducted by Quality Management Nurse (QMS) and Administrator. If concerns are identified, the frequency and or quantity of reviews will be reviewed morthly for three months by the QMS or Administrator. If concerns are identified, the frequency and or quantity of reviews will be reviewed and further education will be provided. **Resident #16.** The SSD desoribed her duities as "making sure residents were not abused, and care plan what they need." Additionally, she stated if the nurse contacted har, she was to take it to the Director of Nursing (DON) and Administrator, However, the SSD stated she did not personally take it to them, it was on the 24. | CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | 0.0938-0391 |
|--|----------|---|---|--------|---------|---|--|-------------|
| NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC COMMARY STATEMENT OF DEFICIENCIES SPRING VIEW HEALTH & REHAB CENTER, INC COMMARY STATEMENT OF DEFICIENCIES SPAN OF CORRECTION SPRING AND ASSOCIATION SPRING AND A | | | | 1`′ | | | | |
| SPRING VIEW HEALTH & REHAB CENTER, INC Major SUMMARY STATEMENT OF DEFIDIENCIES (PAREE IX 120 DEFICIENCY MUST BE PRECEDED BY FULL TAY AND THE PROVIDERS PLAN OF CORRECTION BHOULD BE GROSS-REFERENCED THE APPROPRIATE DEFICIENCY) F 250 Continued From page 16 | | , | 185309 | B, WIN | ic | | 09/0: | 2/2010 |
| F 250 Continued From page 16 him/her that Resident #16 did it to others and it was not good for them. Further review of the record revealed no evidence the facility addressed the incident through Social Services with Resident #18. An interview with the SSD, on 08/20/10 at 11:45 AM, revealed she had been working as the SSD revealed she had been working as the SSD revealed she was called on 07/11/10 (Sinday), at home, due to Resident #18 reporting to the day shift rurse that Resident #18 was asking for sex. The SSD stated flate rolicident report. The SSD stated flate rolicident report. The SSD stated she reading the Resident #18 nurse's notes, dated 07/11/10 in 9:00 AM, the incident "looks like verbal sexuel abuse". The SSD did not document anything in the Social Service Notes and stated she would normally other teams that and did not know why she had not. She stated she roll abbehaviors and update the behavior care plans, but she had not Implemented any new interventions for Resident #18 because he/she was not "upset" and she did not follow up with Resident #16. The SSD described her duties as "making sure residents were not abused, and care pian what they need". Additionally, she stated if the nurse contacted her, she was to take it to the Director of Nursing (DON) and Administrator, However, the SSD stated she did not personally take it to them, it was on the 24 | SPRING V | IEW HEALTH & REHAB | ATEMENT OF DEFICIENCIES | 1 | 7' L | 18 GOODWIN LANE EITCHFIELD, KY 42754 PROVIDER'S PLAN OF CORRECT! | | (X6) |
| him/her that Resident #16 did it to others and it was not good for them. Further review of the record revealed no evidence the facility addressed the incident through Social Services with Resident #18. An interview with the SSD, on 08/20/10 at 11:45 AN, revealed she had been working as the SSD since 07/01/10 with experience working in this position from 06/2009 through 03/20/10. The SSD revealed she was called on 07/11/10 (Sunday), at home, due to Resident #16 had entered his/her room demanding he/she "give him/her some". The SSD stated that no incident report was completed because there was "no contact, no injury and the nurse would have done an incident report". The SSD stated after reading the Resident #16 hot document anything in the Social Service and the did not document anything in the Social Service had stated of the virth of the SSD stated she was responsible to document when residents had behaviors and update the behavior care plans, but she had not. She stated she was responsible to document when residents had behaviors and update the behavior care plans, but she had not implemented any new interventions for Resident #18 because he/she was not "upset" and she did not follow up with Resident #18. The SSD described her duties as "making sure residents were not abused, and care plan what they need." Additionally, she stated if the nurse contacted her, she was to take it to the Director of Nursing (DON) and Administrator. However, the SSD stated she did not personally take it to them, it was on the 24 | | | | 1 | | CROSS-REFERENCED TO THE APPRO | | DATE |
| hour report. Additionally, she remembered discussing the incident at the next day's | F 250 | him/her that Resident was not good for them record revealed no evaddressed the incider with Resident #18. An interview with the AM, revealed she had since 07/01/10 with a position from 06/2009 revealed she was call home, due to Resider shift nurse that Resider som demanding he/s. The SSD thought Resex. The SSD stated completed because the figury and the nurse vereport. The SSD stated completed because the sex. The SSD stated completed because the sex. The SSD stated completed because the figury and the nurse vereport. The SSD stated completed because the sex of the Social Service No "normally chart some know why she had not responsible to documbe haviors and update but she had not imple interventions for Resi was not "upset" and sex of "upset" and sex of "upset" and sex of the nurse count to the Director of No Administrator. However not personally take it hour report. Addition. | #16 did it to others and it in. Further review of the vidence the facility int through Social Services SSD, on 08/20/10 at 11:45 depen working as the SSD experience working in this at through 03/2010. The SSD led on 07/11/10 (Sunday), at int #18 reporting to the day ent #18 had entered his/her she "give him/her some". It is ident #16 was asking for a that no incident report was here was "no contact, no would have done an incident ated after reading the "sontes, dated 07/11/10 at "looks like verbal sexual at not document anything in the sand stated she would thing like that" and did not out. She stated she was tent when residents had a the behavior care plans, imented any new dent #18 because he/she she did not follow up with SD described her duties as ts were not abused, and leed". Additionally, she intacted her, she was to take ursing (DON) and ter, the SSD stated she did to them, it was on the 24 ally, she remembered | | 250 | interdisciplinary intervention. It explained that information gathe utilized in developing the MDS, Care Plan. The Social Service Diparticipated in a three day Social Seminar presented by the Kentuc Association of Health Care Facil Monitoring Measures to Maint going Compliance: A ten percent sample of charts w reviewed to verify that medically social services were identified an as needed. The reviews were con Quality Management Nurse (QM Administrator. An additional ten will be reviewed monthly for threby the QMS or Administrator. If are identified, the frequency and of reviews will be increased and education will be provided. | red is to be RAPS and rector also Service sky ities. ain On- ere related d provided aducted by (S) and percent ee months concerns or quantity | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | D, 0938-0391 |
|--------------------------|---|--|-------------------|---|---|-------------------------|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' | IULTIPLE LDING | CONSTRUCTION | (X3) DATE SU COMPLET | |
| | | 185309 . | B, WIN | IG | | 09/0 | 2/2010 |
| NAME OF PR | OVIDER OR SUPPLIER | | | STREE | T ADDRESS, CITY, STATE, ZIP CODE | | |
| SPRING V | IEW HEALTH & REHAB | CENTER, INC | | 718 | GOODWIN LANE TCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAC | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X8) COMPLETION DATE |
| F 250 | determined and could #16 was "Put on aler with the at 5:20 PM, revealed his/her assigned duting Resident #16's persist incidents and confirm forgotten about addres #18 after the incident. An acceptable Allega was received 09/02/1 verify the removal of included a policy dev inappropriate Sexual 08/30/10. On 08/31/regarding utilizing the assessment process potential risks for inall potential risks were trained to notify the Athe on-call designed immediate intervention trained to notify the crisk and assist in the plan and intervention Additional training was 09/01/10 by the Qual The training included noting specific observing for mood a aide in assessing for training also instructed. | at did not recall what was donly speculate Resident trand was walched". Administrator, on 08/20/10 the SSD did not complete es as it related to addressing stent sexual behaviors to the sed that the SSD had totally essing the needs of Resident of 07/10/10. Itlion of Compliance (AoC) 0. The actions taken to immediate Jeopardy eloped regarding Behavior Management on 10 the SSD was re-educated admission history and | | 250 | | | |
| | | ion that may have impacted | | *************************************** | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SUR COMPLETI | |
|--------------------------|--|--|--------------------------|--|---|----------------------------|
| | | 185309 | B, WING _ | | 09/0: | 2/2010 |
| | ROVIDER OR SUPPLIER | CENTER, INC | | REET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST, BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD 8E | (X8) COMPLETION DATE |
| F 282 SS=J | Interview with the SS re-education and shounderstanding of the the admission historiaide in identifying risverified she would no DON or the on-call davailable. Training by Specialist was verified 09/01/10. The training observation of mood assessing changes is a resident's psychos. The Immediate Jeop on 09/02/10, as alleg scope/severity lower facility's need to contimplementation of sy 483.20(k)(3)(ii) SER' PERSONS/PER CAI. The services provided must be provided by accordance with each care. This REQUIREMENT by: Based on interviews determined the facility were provided in accordance with each care. | avolved in the assessment of ors. SD, on 09/01/10, verified the ewas able to verbalize education regarding utilizing y and assessment process to ke for behaviors. She offy the Administrator and/or esignee if both were not y the Quality Management of 09/02/10 as completed in gincluded documentation, indicators to aide in the behaviors that could impact ocial functioning. ardy was verified removed and in the AoC, with the ed to a "D", based on the inue to evaluate the stematic changes. VICES BY QUALIFIED RE PLAN | F 282 | T404 | View Health r scrvices to accordance care. Identified in nitoring on oring until | 10/01/2010 |

PRINTED: 09/27/2010 FORM APPROVED

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | ··· | | | 0.0938-0391 |
|--------------------------|--|---|-------------------|-----|--|--|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. 6Ui | | PLE CONSTRUCTION | (X3) DATE SUI COMPLET | |
| | • * | 185309 | 8. WIN | 10 | | 09/0 | 2/2010 |
| | OVIDER OR SUPPLIER | CENTER, INC | | 7 | EET ADDRESS, CITY, STATE, ZIP CODE 18 GOODWIN LANE EITCHFIELD, KŸ 42754 | 1 0010 | LIZU IU |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATRMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | ΙX | Provider's plan of correc (Each corrective action sho) Cross-referenced to the appr Deficiency) | JLD BE | (XL) COMPLETION DATE |
| F 282 | #16's history of sexual on 06/15/10. While the plan interventions to a sexual behaviors, the those interventions we the resident's behavior implement intervention abuse of other resident #16 began is behaviors which impart facility on 07/10/10, a 07/15/10, 07/19/10 and the facility while award ensure interventions in managing Resident behaviors and failed it supervision to preven residents in the facility Resident #16 had his pants touching Resident #18 was yell was in bed, during the entered Resident #18 from Resident #18 from Resident #18 staff that Resident #1 doorway and demand in addition, Resident: 07/03/10 by one staff the resident's care plat it was identified the facility was identified the facility and in the staff that Resident #18 in addition, Resident: 07/03/10 by one staff the resident's care plat it was identified the facility and in the facility and in the facility of the facility and in the facility and in the facility of the f | came aware of Resident at behaviors in other facilities are facility implemented care address Resident #16's facility failed to ensure ere effective in managing ors and failed to identify and ons to prevent potential ints. Inaving sexually aggressive acted other residents of the ind continued on 07/12/10, and 07/22/10. Furthermore, are of these incidents, failed to implemented were effective at #16's repetitive sexual to provide appropriate at Resident #16 from abusing and area of the facility. They hand in Resident #14's public area and ling for help. Resident #16 in injuly, when Resident #16 is room and demanded sex are sident #2Z reported to 6 had stood in his/her ind sex. #5 was transferred on instead of two staff as per an, resulting in a fall. | # | 282 | Resident #5; will be transferred utilitial members in accordance with the plan of care. CNA #3 was re-educated DON on 9/1/10 and verbalized und CNAs working on Resident #5's und 07/03/10 will be re-trained by nurse managers and required to give return demonstration to validate following Aid Data Sheet as required. This tratart on 09/07/10 and will be completed to 109/10/10. How Other Residents were Identify that may have been impacted by the Nursis Managers and Care Plan Coordinate review was completed on 9/7/10. The of the review revealed that 22 residents on 200 hall review was completed on 9/7/10. The of the review revealed that 22 residents on 200 hall review was completed on 9/7/10. The of the review revealed that 22 residents on 200 hall review was completed on 9/7/10. The of the review revealed that 22 residentified as needing more than 1 performance of the requirement to nurse aide data sheet, without deviate interviews were completed on 9/9/10. N.A.s interviewed correctly identified as needing more than 1 performed amount of assistance and valuate they understood that the Nurse Sheet was to be followed, with no considered the required assistance. As part of the Quality Assurance predicting attempted to interview 1009 female residents on 7/27/10 and ask anyone ever touched you or cared for manner that you felt was inappropri | ne resident's ted by the erstanding. it on e unit in the Nurse's aining will eted by led his practice: Aide Data ng Unit or. The he findings ents on 100 quired more fors. The esidents erson for Unit erify that follow the tion. These 0. All iffed the alidated Aide Data ne being occess, the 6 of all ed. "Has or you in a ate or made | |
| | implement effective ca | cility's failure to develop and are plan interventions to haviors and prevent abuse | | | | ate or made feel safe | |

manage resident's behaviors and prevent abuse placed residents at risk for serious injury, harm,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | of deficiencies Correction | (X1) PROVIDER/BUPLIER/CLIA IDENTIFICATION NUMBER: | ۸, BUILDII (XX) MŲL) | TPLE CONSTRUCTION | (X2) DATE SU COMPLET | |
|--------------------------|---|---|-------------------------|--|---|-----------------------------|
| | | 185309 | B. WING. | TO MINISTER THE PROPERTY OF TH | 09/0 | 2/2010 |
| | OVIDER OR SUPPLIER | CENTER, INC | ş | FREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY. 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X6) COMPLETION, DATE |
| F 282 | in this facility. The findings include: 1. A review of the fact dated 01/01/07 and resexual abuse defined nature committed for the abuser and in the adult or elderly person's infabuse can include, but Under the Identification as part of the assessible reviewed to determinappropriate behavior catastrophic behavior be care planned as an A review of the facility "Gomprehensive Care revised 03/25/09 and plan will be daveloped and the plan of care when indicated, based response. Review of a closed rewas admitted to the facility mood Disorder and A nurse's note, dated 00 a Certifled Nurse Aide him/her with a urinal, like to shake it don't y boobs, come on let me | cooling and procedure titled a plans", dated 04/16/08 and 09/17/09, included: a care disased on the resident's or that could result in a lincident. Interventions will oppropriate. If policy and procedure titled a plans", dated 04/16/08 and 09/17/09, included: a care disased on the resident's cord revealed Resident #16 collity, on 06/07/10, with Dementia, Unspecified Izheimer's Disease. A 6/09/10 at 2:00 PM, revealed of (CNA) was assisting when he/she stated, "You ou" and "Let me see your | F 28 | F282 (continued) were interviewed, 27 were coder having severely impaired cognitimaking, however all but two proanswers to the direct questions. A Resident Council meeting was 7/27/10 to review what constitut how to report it if they were abus suspected someone else was beir This review of recognizing and rincluded sexual abuse. The Resimeeting was conducted by the Schicter residents who exhibit behas suggest that they have the potent inappropriate sexual behaviors to in the future. This review was edaily tracking records which iden MDS indicators including physicabuse. The records of these resist reviewed and the care givers for interviewed to identify if any befor a sexual nature. None were idroview was completed by Quality Specialist Nurse, Director of Nur Managers. The review was composable of a sexual nature of the review of the review was composable. Measures Implemented or System Prevent Re-occurrence: Re-education will be initiated on Director of Nursing & CNA Mariall CNAs on following the Nurse Sheets for transfer requirements by the interdisciplinary care plan emphasizing that no less assistan provided by staff than is specific | held on ed abuse and sed or g abused. eporting abuse lent Council cial Service of identify viors that may leal to exhibit sward residents ampleted using at the council cial service of identify viors that may lead to exhibit sward residents ampleted using at the council | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIANCE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIANCE (X4) DATE S COMPLIANCE (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE S COMPLIANCE (X6) DATE S COMPLIANCE (X6) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCTION (X6) DATE S COMPLIANCE (X6) DATE S C | | | | | |
|--|--|---|---------------------|--|---|--------------------------------|
| | | 185309 | B. WING | P | 09/0 | 2/2010 |
| NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC | | | S | STREET ADDRESS, CITY, STATE, ZIP COE 718 GOODWIN LANE LEITCHFIELD, KY 42754 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (#ACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (XS) COMPLETION DATE |
| F 282 | Physical document w sexually aggressive be facilities. The History Resident #16 had a hin others' rooms and inappropriate. Additionote entry, dated 06/7. Resident #16 remarked providing care, "Put litthe CNA was "Scared the CNA if she had "Efacility developed a "Eplan dated 06/15/10 vinterventions: 1. Expland the tolerated; 2. Paggressive feelings; present when care proposed to the commented evidence (SS) and Pherein the second proposed the proposed that the residents was no documented evidence Resident #16's sexual impact other residents was no documented intervento ensure other residents be impacted by these The facility assessed moderately impaired a decision making and sehaviors on the Resignal part of the proposed that the residence of the period of the proposed that the | ity received a History and hich detailed Resident #16's sehavior history at other and Physical revealed istory of paoling, wandering acting sexually nally, a review of a nurse's 15/10 at 12:00 PM, revealed ed to a CNA, while she was up (his penis)" and asked if I of It". Resident #16 asked ever been touched". The Behavioral symptoms" care which revealed the following all that such behavior will rovide opportunities to vent 3. Always have 2 CNAs evided; and, 4. Notify Social sysician of any change in sexhibited. There was no e the facility identified that I behaviors could potentially in the facility and there evidence the facility would not behaviors. | F 28 | aide data sheet. Inservicing 9/7/10 and continued at mu sessions through 9/10/10. Nursing will be responsible provide training for any. Checompleted the training prio on 9/10/10 before their nex. The Care Plan team includi Nursing, MDS Coordinator Social Service Director, Ac Dietary Director, Rehab Directory Director, Rehab Directory Director, Rehab Directory and monitoreffectiveness of the approach offectiveness of the approach offectiveness of the approach offectiveness was revised to orders being brought to the Abbreviated Quality Assurance will be reviewed along changes noted on the 24 hochange in condition or order a care plan update will be a member, usually the Unit Mintervention that is decided who updates the care plan with Director of Nursing that updated in the next day's Al Assurance Meeting. If conditions or behaviors a suggest that the current care the care plan will be brough meeting for revision. On will plans will continue to be uprevisions by the charge nurs | Itiple small group The Director of to arrange or IAs who have not r to the last session t shift worked. Ing Director of Unit Manager, tivity Director, rector and ded training of care as wing the clies that are in include physicians morning ance Meeting. The ing with condition our reports. Any r that requires ssigned to a team fanager, to add the upon. The person vill report back to the plan was obreviated Quality re identified that uplan is ineffective, it to the AQA eekends the care dated with needed | |